March 7, 2012

Marlene H. Dortch, Secretary
Federal Communications Commission
Office of the Secretary
9300 East Hampton Drive
Capitol Heights, MD 20743

RE: Request for Waiver and Review of Decision

CC Docket No. 02-6

Contact:

Janice Meyers
Letter of Agency for Klingber Family Center
Janice Meyers Educational Consulting
PO Box 534.
Dobbs Ferry, NY 10522
914-715-2466 phone

BEN: 201020

Klingber Family Center

FRN: 2190528

Request for Waiver

I am requesting a waiver of the FCC Form 471 Window filing requirement that the Item 21 Attachment be received on or before the filing deadline for funding year 2011 due to my accident of March 18, 2011

Argument

In 2006 and 2007, in the *Bishop Perry Order* and the *Academy for Academic Excellence Order*, the Commission and the Bureau, respectively, granted waivers to applicants who missed the FCC Form 471 filing window deadline due to technical malfunctions, school reorganizations, a misunderstanding related to the filing deadline, personal staff emergencies, inadvertent errors, or circumstances beyond their control, including inclement weather.

On March 18, 2011 I had an accident at school and was taken to the emergency room for treatment for an injury to my right knee that left me unable to walk. I was given prescription pain medication. On March 22, 2011 my orthopedic surgeon

decided that I was unable to work. I began receiving NY State Worker's Compensation. I had surgery on March 31, 2011. I returned to work on May 18, 2011. Please find the attached documentation.

FRN 2190528 was filed and certified on 3/20/2011. I was unable to send in the item 21 due to my accident. Please find the attached documentation.

I sent the Item 21 attachment during a PIA review on December 7, 2011. On January 18, 2012 a FCDL was issued and FRN 2190528 was denied due to the following reason:
"DR1: This FRN is denied because the Item 21 Attachment was not received on or before the filing deadline. The Item 21 Attachment is an FCC Form 471 Window filing requirement. Your Item 21 Attachment was received after the filing deadline. FCC Forms 471 with Item 21 Attachments that met the FCC Form 471 Window requirements have funding priority over applications received after the filing deadline. Given that funding demand for FCC Forms 471 filed within the window exceeds the amount available for commitment, we cannot consider this FRN for funding."

I respectfully ask that you waive the deadline for filing the Item 21 attachment based on my illness and extenuation circumstances fund FRN 2190528.

Sincerely,

Janice Meyers

Janice Meyers

000014

* The CVC code is the LAST 3 digits AFTER the first set of numbers printed on the BACK of your card

DOBBS FERRY EMERGENCY MEDICINE PC
P O BOX 36157
NEWARK NJ 07188

STATEMENT DATE	AMOUNT DUE
06/07/2011	$250.00

PATIENT NAME(S)	DATES OF SERVICE
J Meyers #109	03/18/2011 03/18/2011

Return Service Requested

DOB102.A3S2EC000014.J0885J.000014 000014

MAKE CHECK PAYABLE AND REMIT TO:

000014

JANICE MEYERS
98 BELLWOOD AVE
DOBBS FERRY NY 10522 - 2324

DOBBS FERRY EMERGENCY MEDICINE PC
PO BOX 36157
NEWARK NJ 07188-6106

STATEMENT

Service Dates	Procedure Code	Description	Billed	U	Adjusted	Received	Balance
PATIENT NAME Janice Meyers		*PATIENT ACCOUNT NUMBER: 109*					
03/18/2011 03/18/2011	99283	LEVEL 3 MODERATE COMPLEXITY	250.00	1	0.00	0.00	250.00

MESSAGES

* - SERVICE DUE FROM INSURANCE

Physician:
Patient: J. Meyers #109

INSURANCE BALANCE
$0.00

0-30 DAYS	31-60 DAYS	61-90 DAYS	90-120 DAYS	120+ DAYS	PATIENT BALANCE
$0.00	$250.00	$0.00	$0.00	$0.00	$250.00

REFER INQUIRIES TO: DOBBS FERRY EMERGENCY MEDICINE PC Phone: 845-664-9902

SW CNYRxPadMN477288 P Pad 8 of 20 9/15/2010 N

OFFICIAL NEW YORK STATE PRESCRIPTION 2

SCOTT V HAIG MD
LIC: 168044
NPI: 1114941499

700 WHITE PLAINS ROAD SUITE 10 SCARSDALE, NY 10583 (914) 723-4244

PRACTITIONER DEA NUMBER

Patient Name Megan Jan Date 3/11/14

Address

City ______ State ______ Zip ______ Age ______ Sex M F

℞

Out of work until cleared -

MAXIMUM DAILY DOSE (controlled substances only)

Prescriber Signature X S

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'daw' IN THE BOX BELOW

REFILLS ☐ None Refills ______

0MTBBW 21

PHARMACIST TEST AREA:

Dispense As Written

THE HARTFORD

NOTICE THAT PAYMENT OF COMPENSATION HAS BEEN STOPPED OR MODIFIED

CHECK TYPE OF CASE: ☑ WORKERS' COMPENSATION ☐ VOLUNTEER FIREFIGHTER ☐ VOLUNTEER AMBULANCE WORKER

ANSWER ALL QUESTIONS FULLY - TYPEWRITER OR COMPUTER PREPARATION IS REQUIRED

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				
1. WC Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Social Security Number
G0401195	yzc 58853	W106751	03/18/11	

		Address to which notices should be sent
6. Claimant/Name of Deceased	Janice Meyers	98 Bellwood Ave Dobbs Ferry, NY 10522
7. Employer*	A.U.S.S.I.E. Inc	352 Seventh Ave, Suite 12A New York, NY 10001
8. Carrier	THE HARTFORD	PO Box 14472 Lexington, KY 40512

* in VF and VAW benefit cases, the liable political subdivision (or unaffiliated ambulance service as defined in Sec. 30 VAWBL) is deemed to be the "EMPLOYER"

9. County Where Injury Occurred	10. Date Disability Began or Date	11. Avg. Weekly Wage	12. Date 1st Pmt Mailed	13. Date Most Recent Payment Mailed
	3/19/2011	1200 t r	4/5/2011	4/5/2011

14. Description (Diagnosis) of Injury:

15. SUMMARY OF BENEFIT PAYMENTS

Indicate Type of Disability		Period(s) of Payment		Less Days Worked	Number of Weeks	Weekly Rate	Amount
TOTAL/PARTIAL	PERM./TEM	From	To				
		3/19/2011	4/5/2011		2.2	$739.83	$ 1,627.63

DISFIGUREMENT	
LUMP SUM PAYMENT (Included Lump Sum Non-Schedule Adjustment or Lump Sum Advance on a Schedule Loss Award)	
TOTAL AWARD	$ 1,627.63
PENALTY PAYMENT TO CLAIMANT	
LESS: a. Fees to representative:	
b. Reimbursement to:	
c. Other (specify):	
TOTAL DEDUCTIONS (a+b+c) $0.00	
BALANCE TO CLAIMANT	$1,627.63

16. Have benefits been paid in full in accordance with an award of the WCB? ☐ Yes ☑ No If 'No, check and complete items a-c, as appropriate

a. ☐ Claimant returned to work. Date of return: _____ ☐ At pre-injury wages ☐ At reduced wages

b. ☐ There is a change in condition and/or earnings. (A medical report or other supporting documentation must be attached.)

c. ☐ Payments stopped or modified for other reason. (Explain below and/or attach explanation/documentation.)

paying at max rate awaiting C240

17. ☐ NOTICE OF TERMINATION OF TEMPORARY PAYMENTS OF COMPENSATION (Sec. 21-a WCL). Employer or carrier is ceasing payments of Temporary compensation. See special information box on reverse. Last payment was made or _____ Reason for termination of payments:

Prepared by *Deborah Caswell* Dated *4/6/2011*

Official Title *Claims Rep* Telephone No. & Ext. *877 469 9222*

C-8/8.6 (8-00)
Form LC-7132-0

SEE IMPORTANT INFORMATION TO CLAIMANT AND CARRIER ON REVERSE SIDE

For Harford use ONLY	Completed By	Return/Attachment/Check (R/A/C)

PATIENT COPY

Ancillary Medical Report

C-4 AMR

State of New York - Workers' Compensation Board

Use this form to report ancillary medical services such as x-ray, anesthesia, pathology or diagnostic services by other than the attending provider. A medical provider who is only giving clearance for surgery may also use this form. THIS FORM SHOULD NOT BE USED TO REPORT TREATMENT PROVIDED.

Please answer all questions completely, attaching the report for the services provided, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary services, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.state.ny.us.

A. Patient's Information

1. Name: MEYERS, JANICE (Last / First / MI) 2. Soc. Sec. #: [redacted]

3. Mailing address: 98 BELLWOOD AVE (Number and Street) DOBBS FERRY (City) NY (State) 10522 (Zip Code)

4. Home phone #: (914)715-2466 5. Date of Birth: 08 / 28 / 1952 6. Date of injury/onset of illness: 03 / 18 / 2011

7. WCB Case # (if known): 8. Carrier Case #: YZC58853C 9. Patient's Account #: 00012229*1*10

B. Doctor's Information

1. Your name: CATALANO MD, ELIZABETH (Last / First / MI) 2. WCB Authorization #: 13-3997445

3. WCB Rating Code: 13-3997445 4. Federal Tax ID #: 13-3997445 The Tax ID # is the (*check one*): ☐ SSN ☒ EIN

5. Office address: 55 PALMER (Number and Street) BRONXVILLE NY 10708-3403 (City / State / Zip Code)

6. Billing group or practice name: WESTCHESTER ANESTHESIOLOGISTS

7. Billing address: 800 WESTCHESTER AVE S-614 (Number and Street) RYE BROOK NY 10573-1354 (City / State / Zip Code)

8. Office phone #: ( ) 9. Billing phone #: (914)428-5454 10. Provider's NPI #: 13-3997445

11. Referring Doctor: HAIG MD, SCOTT V (Last / First / MI)

C. Billing Information

1. Employer's insurance carrier: HARTFORD ACC & INDEMNITY(WC) 2. Carrier Code #: W

3. Insurance carrier's address: PO BOX 14472 (Number and Street) LEXINGTON KY 40512-4472 (City / State / Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code:	ICD9 Descriptor:
(1) 836.0	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT
(2) 836.1	TEAR OF LATERAL CARTILAGE OR MENISCUS OF KNEE CURRENT
(3)	

Relate ICD9 codes in (1), (2) or (3) to Diagnosis Code column by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
								Start Time: 10:20	Stop Time: 11:23					
03	31	11				2		01400		1 2	1440.00	63		40512-4472

☒ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 1440.00	$	$ 1440.00

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above. ☐ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

CATALANO MD, ELIZABETH	NOTARIZED SIGNATURE ON FILE	ANESTHESIA	04 / 08 / 2011
Name	Signature	Specialty	Date